

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011115

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED APR 1 1963

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY GASCONADE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON		Length of stay in 1b 2 DAYS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST FRANCIS HOSPITAL		d. STREET ADDRESS (If outside, give location) MORRISON, MO.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HACKMANN Last HACKMANN		4. DATE OF DEATH Month MARCH Day 25 Year 1963	
5. SEX MALE	6. COLOR OR RACE CAU	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-25-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY Gen. farming.	
13a. FATHER'S NAME BERRARD HACKMANN		13b. MOTHER'S MAIDEN NAME MARY BARTLMAYER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of no)		17. INFORMANT Clara Hackmann, Morrison, Mo.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, diffuse		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1) Cardiovascular disease, arteriosclerotic 2) Hemiparesis		PART III. If deceased was female was there a pregnancy in last 90 days: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour 4:00 a.m. p.m. Month, Day, Year 3/24/63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION MORRISON, MO	
21. I attended the deceased from 3/24/63 to 3/25/63 and last saw him alive on 3/25/63 Death occurred at 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 3/25/63	
22a. SIGNATURE Michael I. Haffner, M.D.		22b. ADDRESS Washington, MO	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-28-63	
23c. NAME OF CEMETERY OR CREMATORY ASSUMPTION CEMETERY		23d. LOCATION (City, town, or county) (State) MORRISON, MO	
24. FUNERAL DIRECTOR HERMAN BLUMER INC		25. DATE RECD. BY LOCAL REG. 3/26/63	
26. REGISTRAR'S SIGNATURE Leola C. Hickman			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Roger W. Blum

Licensed Embalmer No. 5055

P. O. Address Hermann, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.